PLEASE PRINT OR TYPE

Kentucky Board of Nursing
312 Whittington Pky, Suite 300
Louisville, KY 40222-5172

ATTACHMENT 1

VERIFICATION OF SUPERVISION FOR ADVANCED REGISTERED NURSE PRACTITIONER (ARNP) APPLICANT

To the Applicant

Your employer or the facility where you will be employed must complete this form. Provide the information below, and then forward this form to the applicable employer/facility with a letter requesting its completion. **THE EMPLOYER MUST DIRECTLY MAIL THIS FORM TO THE ATTENTION OF THE "ARNP UNIT" AT THE KENTUCKY BOARD OF NURSING ADDRESS PROVIDED ON THE TOP OF THE FORM.**

ARNP Applicant's Last Name: **ARNP Applicant's First Name:**

Practitioner Type - Designated Nurse: ◯ Anesthetist ◯ Practitioner ◯ Midwife ◯ Clinical Specialist

Employing Facility:

Facility's Address:

City: **State:** **Zip:** -

Facility's Phone #: - - **Employed From (Month/Year):** - **Employed To (Month/Year):** -

Employment Position:

DO NOT WRITE BELOW THIS LINE
INFORMATION BELOW THIS LINE IS TO BE COMPLETED BY THE EMPLOYING FACILITY

To the Employer

Complete this portion of the Verification of Supervision for ARNP Applicant form, and then MAIL THIS FORM DIRECTLY TO THE "ARNP UNIT" AT THE KENTUCKY BOARD OF NURSING ADDRESS LISTED ON THE TOP OF THE FORM. This form verifies that the ARNP applicant listed above will be practicing under the supervision* of an advanced registered nurse practitioner of the same specialty area or a licensed physician until the results of the certification examination have been received. **All individuals providing such supervision must sign this form in the spaces provided below or on the attached sheet.**

* Supervision is defined in KAR 20:056, Section 4(1)(b) as periodic observation and evaluation of the applicant's practice to validate that the practice has been performed according to established standards. The supervisor shall be immediately available either on site or by telephone.

I hereby agree to provide the required supervision to the above named applicant for ARNP registration:

Supervising ARNP

Signature _____ Date _____

KY RN License # _____ ARNP # _____

Supervising Physician

Signature _____ Date _____

KY License # _____

Space for additional signatures is provided on the attached sheet, if needed.

Additional Signatures

Supervising ARNP

Signature ____________________ Date __________

KY RN License # __________ ARNP # __________

Supervising Physician

Signature ____________________ Date __________

KY License # ____________________

Supervising ARNP

Signature ____________________ Date __________

KY RN License # __________ ARNP # __________

Supervising Physician

Signature ____________________ Date __________

KY License # ____________________

Supervising ARNP

Signature ____________________ Date __________

KY RN License # __________ ARNP # __________

Supervising Physician

Signature ____________________ Date __________

KY License # ____________________

Supervising ARNP

Signature ____________________ Date __________

KY RN License # __________ ARNP # __________

Supervising Physician

Signature ____________________ Date __________

KY License # ____________________

Supervising ARNP

Signature ____________________ Date __________

KY RN License # __________ ARNP # __________

Supervising Physician

Signature ____________________ Date __________

KY License # ____________________

Employer Comments